

EXHIBIT 280

**MODEL LETTER - NOTICE OF TERMINATION OF
PROVIDER AGREEMENT**

(Date)

Community Mental Health Center Name
Address
City, State, ZIP Code

Dear _____:

RE: Provider Number (**Provider Number**)

On **(date)**, we notified you of our findings that the **(provider name)** Community Mental Health Center (CMHC) failed to provide the following core Public Health Service Act (PHSA) services as mandated by §1913(c)(1) of the PHSA and required by §1861(ff)(3) of the Social Security Act (the Act) to qualify as a CMHC for Medicare purposes. We informed you that if you had additional evidence to show that you provided the core services that you had 15 calendar days to respond to our findings.

(The RO should choose one of the following statements:)

- The 15 calendar day period has expired and you failed to submit evidence of having provided the following core services; or
- On **(date)**, you provided additional information in the form of **(list materials submitted)**. We have reviewed this documentation. It **(does/does not)** change our earlier decision that you failed to provide the core PHSA services.

(If the RO has determined that the additional material submitted by the CMHC changes the earlier decision of unmet PHSA core service requirements, the notification is complete.)

(If the CMHC presented additional materials as evidence of its compliance with the PHSA core requirements, and the RO has determined that this material does not change its earlier decision concerning the unmet core requirements, note the evidence submitted and respond to the information and documents; or lack thereof with respect to the core services you found the provider did not meet with a detailed explanation of why it has not changed the determination and insert the following paragraphs:)

(Name)
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(Date)

As we informed you earlier, in accordance with §1866 of the Social Security Act and 42 CFR Part 489.53, CMS may terminate a CMHC's provider agreement to participate in the Medicare program when it determines that a CMHC is not complying with the provisions of the Act, applicable regulations, or the provider agreement.

Based on our determination that (**provider name**) does not provide (**list core services not furnished**) of the four core services, we conclude that it has failed substantially to comply with the provisions of its provider agreement, or to meet the provisions of §1861(ff)(3), which require it to provide all four of these services, and therefore, its provider agreement must be terminated in accordance with §1866 of the Act, and 42 CFR Part 489.53. The date on which the Medicare provider agreement terminates is (**date**).

We will publish a legal notice in the newspaper 15 calendar days prior to termination. You will be advised of publication of the notice.

If you believe this decision is not correct, in accordance with 42 CFR Part 498.5(a)(2), you must file a request with CMS within 60 days from receipt of this notice for a hearing before an Administrative Law Judge. The request must state the issues, or the specific findings of fact with which you disagree, and the specific reasons for the disagreement. Your request for a hearing should be sent to: (**name and address**).

If you have any additional questions concerning this determination, please direct your inquiry to:

Sincerely yours,

Associate Regional Administrator
(or its equivalent)